Washington State Department of Social & Health Services
MAA Medical Assistance Administration

MEDICAL ASSISTANCE ADMINISTRATION

ORAL ENTERAL NUTRITION WORKSHEET

CLIENT INFORMATION	
CLIENT NAME	CLIENT PIC
Is Client Women, Infants, and Children Program (WIC*) Eligible? ☐ Yes ☐ No (attach WIC statement of denial)	
PROVIDER INFORMATION	
VENDOR NAME	VENDOR MEDICAID PROVIDER NUMBER
VENDOR TELEPHONE NUMBER	FAX NUMBER
SERVICE REQUEST INFORMATION	
NUTRITIONAL REQUESTED	HCPCS CODE
Quantity in units per day (100 calories equals 1 unit)	Length of Need
Provide all applicable diagnoses (ICD-9 Codes and description)	MEDICAL
	NUTRITIONAL

CLIENT

0-36 months _____ % on growth chart, 3-17 years _____% on growth chart or BMI _____, 18 or older BMI _____

To receive orally administered Enteral Nutrition products, a client must have at least one of the following medical conditions, subject to the criteria and ICD-9 codes listed.

Malnutrition/Malabsorption: ICD-9-CM Codes - 260, 261, 263.0, 263.2, 579, 579.0, 579.2, 579.8

Covered with Prior Authorization (PA) for a maximum of six (6) months per request when;

1. The condition is the result of a primary diagnosed disease state; and
2. A weight-for-length at or less than 5% if the client is younger than age three; or
3. Less than 5% if the client is age 3 - 17; or
4. Body Mass Index (BMI) less than or equal to 18.5 if the client is age 18 or older.

Adult/Child Failure to Thrive: ICD-9-CM Codes - 783.7

Covered with Prior Authorization (PA) for a maximum of six (6) months per request when;

1. The medical condition organic in nature without cognitive or emotional/psychological impairment; and
2. A weight-for-length at or less than 5% if the client is younger than age three;
3. A BMI of less than 5% if the client is at least age 3 but younger than age 17;
4. A BMI of less than or equal to 18.5, an albumin level of 3.5 or below, and a cholesterol level of 160 or below if the client is age 18 or older.

AIDS: ICD-9-CM Codes - 042

Covered with Prior Authorization (PA) for a maximum of one (1) year per request when;

1. Is in a wasting state; and
2. A weight-for-length at or less than 5% if the client is younger than age 3;
3. A BMI at or less than 5% if the client is older than age 3 but younger than age 17;
4. A BMI equal to or less than 18.5 if the client is age 18 or older.

Amino Acid, Fatty Acid and Carbohydrate Metabolic Disorders: ICD-9-CM Codes - 270 through 270.8, 271 through 271.8, 272.0 through 272.8

Covered with Prior Authorization (PA) for a maximum of one (1) year per request.

1. No other specified criteria required.

Chronic Renal Failure: ICD-9-CM Codes - 585

Covered with Expedited Prior Authorization (EPA) for a maximum of one (1) year per request.

1. Clients receiving dialysis.
2. Have a fluid restrictive diet in order to use nutrition bars.

Decubitus/Pressure Ulcers: ICD-9-CM Codes - 707.0

Covered with Expedited Prior Authorization (EPA) for a maximum of three (3) months per request.

1. Clients with a stage III or greater wound; and
2. Who have an albumin level of 3.2 or below.

Dysphagia: ICD-9-CM Codes - 787.2

Covered with Prior Authorization (PA) for a maximum of six (6) months.

1. Needed to transition from tube to oral feed or require thickeners to aid swallowing; and
2. Be evaluated by a speech therapist.

Malignant Cancers: ICD-9-CM Codes - 140 through 208.9, 230 through 234.9

Covered with Expedited Prior Authorization (EPA) for a maximum of six (6) months per request for clients.

1. Client must be receiving chemotherapy.

MAA requires the following documentation to justify medical necessity:

- What are the client's physical limitations and expected outcome?
- What is the client's current clinical nutritional status? Please include the relationship between the client's diagnosis and nutritional needs?
- Weight loss history and comparison of the client's actual weight to real body weight and current body mass index (BMI).
- Detailed documentation of why less costly traditional foods that can be blenderized are not appropriate.

REQUIRED PRESCRIBER CERTIFICATION STATEMENT	
I certify that I am the prescriber identified on this form. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge.	
PRESCRIBER'S SIGNATURE (SIGNATURE AND DATE STAMPS ARE **NOT** ACCEPTABLE)	DATE
PRINTED NAME	

DSHS 13-743 (12/2004)

A copy of the prescription must accompany this form. Attach lab results and other documentation as necessary. The provider must retain copies of all documentation for five (6) years.